WISCONSIN

DEPARTMENT OF WORKFORCE DEVELOPMENT
Division of Economic Support
Bureau of Work Support Programs

TO: **Economic Support Supervisors**
Economic Support Lead Workers
Training Staff
FSET Administrative & Provider Agencies
Child Care Coordinators
W-2 Agencies

FROM: Stephen M. Dow
Policy Analysis & Program Implementation Unit
Work Programs Section

BWSP OPERATIONS MEMO

No.: 00-07

File: 1101

Date: 02/17/2000

Non W-2 [X] W-2 [X] CC [X]

PRIORITY: High

SUBJECT: **ALCOHOL & OTHER DRUG ABUSE (AODA) AND MENTAL HEALTH (MH) CONFIDENTIALITY**

CROSS REFERENCE: Wisconsin Statute 51.30 (4)(d)
Wisconsin Administrative Code HHS 92.03 (3) & 92.06
Code of Federal Regulation 42 CFR Part 2.

EFFECTIVE DATE: Immediately

PURPOSE

This memo explains the AODA and MH confidentiality law, the requirements for obtaining confidential information, and appropriate documentation of confidential information in the participant's case record.

BACKGROUND

DES currently uses 2 forms (DES-10779 and DES-10779-1) for the release of confidential information from AODA and/or MH services providers. W-2 and County/Tribal Human/Social Service agencies have had difficulties in obtaining information from AODA/MH providers because the current forms do not meet federal and state requirements for the release of this information.

AODA & MH CONFIDENTIALITY LAW

People with substance abuse problems are likelier to seek (and succeed at) treatment if they are assured that their need for treatment will not be disclosed unnecessarily to others. The Federal drug and alcohol confidentiality regulations are stricter than most other confidentiality

rules. In general, they restrict the disclosure and use of "patient identifying" information about individuals in substance abuse treatment or seeking substance abuse treatment. Patient identifying information is information that reveals that a person is receiving, has received, or has applied for substance abuse treatment. What the regulations intend to protect is not the individual's identity, but rather his or her identity as a participant in or applicant for substance abuse treatment.

These regulations apply to holders, recipients, and seekers of patient identifying information. An individual or program in possession of such information (for example, a federally assisted substance abuse program) may not release it except as authorized by the patient. Anyone who receives such information from a substance abuse program (for example, a W-2 agency) may not redisclose it without patient consent and cannot retain this information in a location where patient confidence cannot be maintained.

However, the restrictions on disclosure in these regulations do not apply to communications of information between or among personnel having a need for the information in connection with their duties if the communications are:

1. Within a program; or,
2. Between a program and an entity that has direct administrative control over the program.

OBTAINING CONFIDENTIAL INFORMATION

Effective immediately, DES-10779 is revised and DES-10779-1 is obsolete. It is not necessary to have 2 forms since the revised DES-10779 serves the purpose of both.

Begin immediate use of DES-10779 (R. 12/99), *Authorization for Disclosure of Confidential Information*.

The revised form meets federal and state requirements for the confidential release of AODA, MH, and AODA/MH information. It ensures that communication between the treatment provider and the W-2 and county/tribal human/social service agency will occur. It also allows for better coordination of activities, development/revision of the Employability Plan, and the ability to receive attendance records and progress summaries.

The forms retention policy for DES-10779 still applies (see Operations Memo 98-82). Obtain DES-10779 (R. 12/99) from:

1. DES Forms Repository at
   <http://workweb.dwd.state.wi.us/Notespub/bwiforms/defualt.htm>.

2. Barb Albrecht
   201 E. Washington Ave., P.O. Box 7935
   Madison, WI 53707-7935
   Fax: (608) 267-3240
   Email: albrecba@dwd.state.wi.us

DOCUMENTATION IN THE PARTICIPANT'S CASE RECORD

The specific documentation of confidential patient identifying information should always occur in the paper case record. Due to federal restrictions about the redisclosure of confidential AODA or MH information, documentation cannot occur in CARES screen CMCC because this information is in a location where patient confidence cannot be maintained. Cross-referencing of confidential information should occur in CMCC as long as specific patient identifying information is not included.

Patient identifying information includes diagnosis, prognosis, identification of the treatment facility, the participant's AODA or MH treatment plan, or acknowledgement of treatment activities.

CONTACTS

Regional Offices

Area Administrator

Central Office

DES CARES & Policy Call Center	Email:	carpolcc@dwd.state.wi.us
	Telephone:	(608) 261-6317 (Option #1)
	Fax:	(608) 261-6968

Note: Email contacts are preferred. Thank you.

WISCONSIN DEPARTMENT OF WORKFORCE DEVELOPMENT
Division of Economic Support

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m)].

Regarding the records of:

Name (Last, First, MI)	Date of Birth		
Social Security Number (SSN)	PIN		
Address	City	State	Zip Code

I understand that I am authorizing the disclosure of confidential information to the W-2, County or Tribal Human/Social Services agency and that information about my condition and/or treatment may be communicated among personnel at these offices who have a need for the information in connection with their duties.

I hereby authorize and request:

W-2, County or Tribal Human/Social Services Agency	Telephone ( )		
Address	City	State	Zip Code

TO: (Check ✔ one) ☐ **Disclose to** ☐ **Receive from** ☐ **Or exchange information with**

Name of Agency/Organization/Person	Telephone ( )		
Address	City	State	Zip Code

This information is needed for eligibility determination/continuation, the development/revision of the above named individual's Employability Plan, communication, progress summaries, attendance verification, and/or establishment of good cause for non-cooperation with child support requirements.

Type or extent of information to be disclosed (Check ✔ all applicable categories)

☐ Psychiatric ☐ Alcohol and Drug ☐ Specific Request: _____

	Psychiatric Evaluation including Diagnosis/Prognosis		Medical Reports/Physical Exams including Diagnosis/Prognosis
	Psychiatric/Psychotherapy Progress Summaries		Urinalysis Results
	Psychological Evaluation		Treatment Plans
	Alcohol/Drug Initial Assessment/Evaluation		Psychosocial History
	Attendance Records		AODA Progress Summaries
	Legal Records		Birth, Marriage, and Divorce Records

I understand that I may revoke this authorization, in writing, at any time except where information has already been released as a result of this authorization. This authorization will automatically expire one year from the date of signature unless indicated and initialed below.

_____ Authorization expires as of _____/_____/_____ (Date)

_____ Authorization expires after the following action takes place:_____

Wisconsin Statute 51.30 (4)(d), Wisconsin Administrative Code HHS 92.03 (3), 92.06, and 42 CFR Part 2.

White: Disclosing Agency Yellow: Participant Pink: Case Record

DES-10779 (R. 12/99) **RETAIN COMPLETED FORM IN CASE RECORD**

As evidenced by my signature below, I hereby authorize the disclosure of records to the person or agency as specified.

THIS FORM MUST BE SIGNED AND DATED BY THE PARTICIPANT (OR A PERSON LEGALLY AUTHORIZED TO DISCLOSE FOR THE PARTICIPANT) AND A WITNESS FROM THE W-2, COUNTY OR TRIBAL HUMAN/SOCIAL SERVICES AGENCY FOR THE DISCLOSURE OF THE REQUESTED INFORMATION TO OCCUR.

Participant's Signature	Date Signed
Person Legally Authorized to Disclose for the Participant's Signature	Date Signed
Agency Witness's Signature	Date Signed

THE FOLLOWING APPLIES TO YOU ONLY IF THE RECORDS AUTHORIZED FOR RELEASE ON REVERSE SIDE RELATE TO YOUR TREATMENT FOR MENTAL ILLNESS, DEVELOPMENTAL DISABILITIES, ALCOHOL, OR DRUG ABUSE:

The patient who is the subject of the records covered by this authorization, in most cases, has the right to inspect and receive a copy of the material to be disclosed pursuant to this consent form. Except for records of medication and somatic treatment, this right may be denied by the treatment facility director, or designee, during the patient's treatment under certain circumstances. A uniform and reasonable fee may be charged for a copy of the records. The fee may be reduced or waived in accordance with agency policy for those patients who show an inability to pay.

This information has been disclosed to you *(the W-2, County or Tribal Human/Social Services Agency)* from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you *(the W-2, County or Tribal Human/Social Services Agency)* from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

A COPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL

FOR OFFICE USE ONLY

Information Requested: _____

_____

_____

_____

By: _____ **Title:** _____

Date: _____

Response(s): _____

_____

_____

_____

_____

_____

_____

_____

Initials: _____